



Janet Napolitano, Governor
Anthony D. Rodgers, Director

801 East Jefferson, Phoenix AZ 85034
PO Box 25520, Phoenix AZ 85002
phone 602 417 4000
www.ahcccs.state.az.us

Our first care is your health care

ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

March 16, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: File Code CMS-2258-P

Please accept the following questions and comments from the Arizona Health Care Cost Containment System (AHCCCS), the single state agency responsible for administering Arizona's Medicaid program, in response to the portion of the Federal Register Notice of January 18, 2007 (72 FR 2236) applicable to 42 C.F.R. Parts 433, 447, and 457.

For ease of review, AHCCCS has organized its response by general topic, with the proposed Federal requirements initially stated and the correlating question or comment thereunder.

Retention of Payments

42 C.F.R. § 447.207, as proposed, would require all providers "to receive and retain the full amount of the total computable payment provided to them under the approved State plan or approved provisions of a waiver or demonstration if applicable."

- The preamble to the proposed rule at 72 FR 2242 explains that the purpose of this section is to strengthen efforts to remove any potential for abuse involving the re-direction of Medicaid payments by Intergovernmental Transfers ("IGTs") in the future. The section itself, however, makes no reference to IGTs. 42 C.F.R. § 447.207 should be clarified such that the provisions only apply to situations in which an IGT is involved.
- During a phone call with the States on January 25, 2007, CMS indicated that an expenditure must have occurred before a unit of government can certify an expenditure to the Medicaid agency. That expenditure could either be in the form of: 1) a payment by a unit of government to a provider, or 2) a governmental provider incurring expenses associated with the delivery of care. In either case, CMS indicated that once a unit of government certifies a "valid" expense, the provider has been paid. There is concern that the proposed retention requirements make it possible for a governmental provider to assert it is entitled to 100% of the FFP returned to the State on the basis of its expenditure, and the State's retention of any of the FFP constitutes a violation of this proposed rule. 42 C.F.R. § 447.207 should be clarified to clearly state:

- Once a governmental provider certifies an expenditure, the retention of payments as required by the proposed rule has been satisfied.
 - The distribution of FFP from the Medicaid agency to any certifying unit of government is not a relevant factor in measuring compliance with the proposed rule.
 - The State may withhold a portion or the entire amount of FFP resulting from a CPE.
- Health care providers may be subject to taxation, licensing, and other fees that are generally applied to the private sector or to the health care industry at large. There is some concern that the proposed rule would enable providers to assert that they should not be subject to normal operating expenses, which have no direct connection to Medicaid, in as much as they are required to retain the full amount of the total computable payment. 42 C.F.R. § 447.207 should be clarified to:
 - Clearly state that “normal operating expenses including taxes, licensing, other fees associated with the cost of conducting business that are unrelated to Medicaid and in which there is no connection to Medicaid payments” are not affected by the retention requirements of the proposed rule and are not included in the calculation of a State’s net expenditures.
- The proposed requirement to retain full payments conflicts with the provisions of Section 1903(w) (codified at 42 U.S.C. §1396b) which clearly contemplates that providers can return certain portions of payments as bona fide donations and permits certain qualifying health care taxes. 42 CFR §447.207 should be clarified to:
 - Clearly allow donations and taxes as permitted by Section 1903(w) even if a Medicaid payment is the source of those donations or tax payments.

Managed Care Organizations

At 42 FR 2236, the preamble to the proposed rule states that the provisions related to cost limits do not apply to Medicaid Managed Care Organizations (“MCOs”) or SCHIP providers. At 42 FR 2240, the same cost limit exception for MCOs and SCHIP providers is repeated. However, nowhere else in the proposed rule are MCOs mentioned. There is confusion as to the meaning of the phrase “except that Medicaid managed care organizations ... are not subject to the cost limit provision of this regulation.” The preamble and wherever appropriate in the proposed rule should be clarified to:

- Specifically indicate that MCOs, including prepaid inpatient health plans, are not subject to the proposed rule’s cost limitation requirements with respect to both a State’s payment to a MCO and to a MCO’s payment to governmental providers.

Pursuant to proposed 42 C.F.R. § 447.206(c)(1) and subject to exceptions related to Indian Health Service and tribal facilities, “all health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider’s cost of

providing covered Medicaid services to eligible Medicaid recipients.” The language does not seem to provide an exception for payments made by MCOs. 42 C.F.R. § 447.206 should be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Pursuant to proposed 42 C.F.R. § 447.272(b)(4) and subject to exceptions related to the Indian Health Service, tribal facilities, and Disproportionate Share Hospitals, Medicaid payments to State government operated facilities and non-State government operated facilities must not exceed the individual provider’s cost. 42 C.F.R. § 447.272(b)(4) should be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Proposed 42 C.F.R. § 447.321(b)(4), which largely mirrors 42 C.F.R. § 447.272(b)(4), limits Medicaid payments for outpatient services to the individual provider’s cost. 42 C.F.R. § 447.321(b)(4) should also be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Disproportionate Share Hospitals (DSH)

Pursuant to proposed 42 C.F.R. § 433.51(b)(3), CPEs must at a minimum “demonstrate the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the state plan.” With respect to DSH, it is unclear whether DSH payments are *services to eligible individuals receiving medical assistance* or are payments *in administration of the state plan*. 42 C.F.R. § 433.51 should be clarified to:

- Indicate how and where DSH payments fit into proposed rule requirements.

Proposed 42 C.F.R. § 447.206(c)(1) states that “all health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider’s cost of providing covered Medicaid services to eligible Medicaid recipients”. One of the purposes for DSH payments is to help ensure that States provide adequate financial support to hospitals that serve a disproportionate number of low-income patients with special needs. Therefore DSH payments are not solely made to *provide covered Medicaid services to eligible Medicaid recipients*. When read literally, this section appears to prohibit DSH payments for low income patients with special needs. 42 C.F.R. § 447.206 should be clarified to:

- Specifically recognize DSH in the cost limit provision of the rule.

Proposed 42 C.F.R. § 447.272 and 42 C.F.R. § 447.321 set forth the application of upper payment limits to inpatient services and to outpatient hospital and clinical services respectively. Whereas, 42 C.F.R. § 447.272 contains exceptions for IHS and DSH, 42 C.F.R. § 447.321 contains an exception only for IHS. There is concern that this omission may prohibit or restrict DSH payments for outpatient hospital services. 42 C.F.R. § 447.321 should be clarified to:

- Provide the same exception for DSH as contained in 42 C.F.R. § 447.272.

The preamble to the proposed rule at 72 FR 2239 specifies that tax revenue contractually obligated between a unit of State or local government and health care providers to provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments. The example fails to recognize that a tax levied to support indigent care and is ultimately used to reimburse a hospital for its provision of inpatient services for indigent care, may serve as the basis for that government unit's CPE for DSH purposes. The preamble should be clarified to:

- Indicate that the use of taxes levied to support indigent health care can serve as the basis for CPE for DSH purposes.

Administrative Burden

CMS has indicated its disapproval when States make Medicaid payments in excess of costs to governmentally operated providers as it is considered inconsistent with the principles of economy and efficiency. As such, the proposed rule at 72 FR 2241 seeks to limit reimbursement to actual costs for governmental providers. In order to effectuate cost-limited reimbursement, governmental providers would be required by the proposed 42 C.F.R. § 447.206 to utilize a cost report or other auditable documentation. Additionally, 42 C.F.R. § 433.51(b)(3), 42 C.F.R. § 447.272, and 42 C.F.R. § 447.321 would be changed to conform with cost-limited reimbursement requirements.

The application of the proposed rules to all Medicaid programs and all governmental providers is overly broad and imposes administrative burdens and expenses in situations where abusive practices are unlikely to occur. CMS should consider providing exemptions to the proposed rules in the following circumstances:

- *Exemption for entire Medicaid programs.* In circumstances where fee for service payments to governmental providers constitutes only a small percentage of a State's total medical assistance payments (e.g., less than 5%) due to either the widespread use of managed care or the relative lack of governmental providers, the entire Medicaid program should be exempt from the rules. 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should all be amended to:

- Exempt a State and its governmental providers from their provisions when the percentage of a State's fee for service payments to governmental providers constitutes less than a certain percentage of total medical assistance payments.
- *Exemption for governmental providers paid based on a fee schedule applicable to both governmental and non-governmental providers.* As described at 72 FR 2241, the requirement for cost-limited reimbursement is based, in part, on CMS' concern that payment in excess of cost is flowing to governmental providers and is either being used to subsidize health care operations unrelated to Medicaid or returned to the State as an additional source of revenue. A reimbursement system in which a single rate schedule is applied to governmental and non-governmental providers alike, and no supplemental payment is made to governmental providers except for DSH and GME, would appear to assuage this concern. Additionally, such a reimbursement system would serve to encourage economy and efficiency in governmental providers. As such, in the event the proposed exemption described in the previous bullet is unacceptable as overly broad, 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should alternatively be amended to:
 - Exempt governmental providers from their provisions when the State's reimbursement system applies the same fee schedule to all providers of the service in the State (or in a region) and no supplemental Medicaid payment is made in addition to the fee schedule except for DSH and GME.
- *Exemption for governmental providers receiving only a nominal amount of payments and paid based on a fee schedule applicable to both governmental and non-governmental providers.* The requirement to utilize a cost report or other auditable documentation will cause a hardship on governmental providers that only receive a nominal amount of Medicaid payments. In fact, the costs incurred by a governmental provider associated with establishing and maintaining a cost report could, in certain situations, exceed total Medicaid payments received by the governmental provider. For example, fire districts often provide ambulance services, and ambulances sometimes attend to Medicaid recipients. Associated reimbursement may be on a fee-for-service basis. School districts also provide critical services as part of the State Plan and the administrative burden imposed, on particularly smaller districts, by the proposed regulations, could effectively end their ability to receive Medicaid reimbursement. The blanket application of the rule to all governmental providers, regardless of the total amount of reimbursement received, prohibits a State's compliance with the economy and efficiency provisions of Section 1902 (a)(30)(A) of the Act, which is the very issue CMS seeks to resolve. Furthermore, where the cost of establishing and maintaining a cost report exceeds the Medicaid reimbursement, governmental providers may decline to participate in the program. As such, in the event the proposed exemptions described in the previous bullets are overly broad, revenue thresholds should be included in order for cost reporting requirements to apply. Accordingly, 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should all be amended to:
 - Exempt governmental providers from the provisions of the proposed rules if:

- The governmental provider is reimbursed on a fee schedule that is faced by all providers of the service in the state (or in a region) and no supplemental Medicaid payment is made in addition to the fee schedule except for DSH and GME;

And

- The governmental provider receives Medicaid payments that are less than a fixed amount during a fiscal year (e.g., \$500,000), or less than a fixed percentage amount of the entire operating budget of the governmental provider (e.g., 5% of the total revenue of the government).

As described at 72 FR 2241 and in the proposed 42 C.F.R. § 447.206(d), regardless of whether or not a Medicaid cost reimbursement payment system is funded by CPEs, governmentally-operated providers must file annual cost reports. The definition of provider contained in 42 C.F.R. § 433.50(a)(1), which is referenced by 42 C.F.R. § 447.206(d), does not specifically mention professional services. Therefore, the cost reporting requirements of licensed professionals (e.g., physicians, nurses, therapists) that are employed by, and bill under the provider number of, public entities are not sufficiently clear. In order to protect professional service providers from the administrative burden associated with having to report costs, and the State from the administrative burden associated with having to review the cost reports of professional services providers, 42 C.F.R. § 433.50(a)(1) and 42 C.F.R. § 447.206(d) should be amended to:

- Exempt professional service providers under the employ of, or billing under the provider number of, a unit of government.

Also as described at 72 FR 2241 and in the proposed 42 C.F.R. § 447.206(d), under a Medicaid cost reimbursement payment system funded by CPEs, States may utilize most recently filed cost reports to develop interim Medicaid payment rates and may trend these interim rates by an applicable health care-related index. Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made. Final reconciliation must also be performed by reconciling the interim payments and interim adjustments to the finalized cost report for the spending year in which interim payment rates were made.

- In general, the process described above is administratively burdensome for both the Medicaid agency and the governmental provider. The procedure outlined in the proposed 42 C.F.R. § 447.206(e) is less burdensome in that it only mandates a single “review” when CPEs are not being used to fund payments to governmental providers. 42 C.F.R. § 447.206 should be amended to:
 - Eliminate the methodology for payment currently set forth in 42 C.F.R. § 447.206(d), in favor of having the methodology set forth in 42 C.F.R. § 447.206(e) apply to both CPE and non-CPE scenarios.

Timeframe for Compliance

Currently, States must comply with the proposed rule by September 1, 2007. The date is referenced in proposed 42 C.F.R. § 447.206(g), 42 C.F.R. § 447.272(d)(1), and 42 C.F.R. § 447.321(d)(1). Because State legislative authority is a prerequisite to compliance with many of the provisions set forth therein, either a transition period should be established or the September 1, 2007 deadline should be extended. 42 C.F.R. §§ 447.206(g), 447.272(d)(1), and 447.321(d)(1) should be amended to:

- Permit States up until September 1, 2008 to fully comply with the provisions of the proposed rule.

Thank you for the opportunity to comment on the proposed rule. Should you have any questions, please do not hesitate to contact Tom Betlach at (602) 417-4483.

Sincerely,

Anthony D. Rogers
Director